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2005 Health Insurance Market Report

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The *2005 Health Insurance Market Report* was prepared by Jeffrey E. Hawley, Ph.D. of the Health Insurance Division for the Utah Insurance Commissioner pursuant to Utah Code Annotated (U.C.A.) § 31A-2-201(7).

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Executive Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department.

Approximately 69 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 32 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic health insurer.

A key function of the Utah Insurance Department is to assist consumers with questions and concerns they may have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the primary agency within the Utah Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the number of consumer complaints received by the Utah Insurance Department has declined every year since 1999. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last six years, there have been four significant trends in the comprehensive health insurance market that the Utah Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined steadily since 1999. This change is mainly due to a decrease in the number of small foreign health insurers participating in the comprehensive health insurance market. In contrast, there has been little or no change in the number of medium to large health insurers. Large domestic health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market. This decline has affected a small portion of the marketplace and the number of large health insurers offering comprehensive health insurance has remained stable since 1999.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from $149 during 2003 to $162 during 2004, an increase of 8.7 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that health insurers contract to pay for. For example, Utah's health insurers experienced a 7.2 percent increase in losses per member per month from 2003 to 2004. These pricing pressures are not unique to Utah and are being driven by national health care

trends that are affecting most states in a similar way. Although these increases are difficult, Utah's health insurance premiums appear to be lower than the national average. Based on data from the NAIC financial database, the average cost for comprehensive health insurance coverage was $219 per member per month during 2004. Although this comparison does not control for differences in benefits, health status, or demographics, this national estimate is higher than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

The percentage of Utah residents covered by comprehensive health insurance has declined steadily from 1999 to 2004. Based on the available information, this trend appears to be primarily due to a shift by large employers and other large group plans from commercial insurance to self-funding arrangements. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

Over the last ten years the top insurers in the comprehensive health insurance industry have experienced an average financial gain of 0.22 percent. This trend has improved since 1999, however, with the core of the industry experiencing an average financial gain of 1.25 percent over the last six years. Although premiums have increased significantly during this period, the financial data from Utah's health insurers suggest that they are operating on very conservative financial margins and appear to be only charging enough premiums to cover their costs. Generally, Utah's health insurers are financially stable and are able to meet their financial obligations to Utah consumers.

As requested by the Utah Legislature, the Utah Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are reported in the Appendix.

Introduction

For most people, health insurance is essential for managing the costs of personal health care. Health insurance protects against the risk of financial loss that can occur from unexpected accidents and illnesses. It also provides a way for chronic health problems to be treated and managed in ways that many people could not otherwise afford. Because health insurance is so important to the citizens of Utah, it is in the interest of the State to monitor and maintain a stable health insurance industry.

An important purpose of the Insurance Department is to ensure that Utah has an adequate and healthy insurance market. The purpose of this report is to provide an annual evaluation of Utah's commercial health insurance market as required by Utah Code Annotated (U.C.A.) § 31A-2-201(7).

What is Health Insurance?

In general, health insurance transfers the risk of paying for personal health care from an individual to an entity that pools the risk. The individual shares in the management of his or her personal health care risk through the use of deductibles, coinsurance, and the health benefits provided by insurance. Individuals obtain their health benefits from one or more of three health insurance sources: government sponsored health benefit plans, employer sponsored self-funded health benefit plans, and commercial insurance health benefit plans. The health benefits provided by these plans will range from comprehensive major medical benefits to single disease or accident only benefits.

Government sponsored health benefit plans are government programs that provide health insurance benefits. These programs may be funded entirely by government funds or by a combination of government funds and premiums paid by the covered individuals enrolled in the program. The risk of financial loss is borne by the government. These programs may provide comprehensive major medical health insurance benefits (such as Medicaid and Medicare), limited primary health insurance benefits (such as county health clinics), or limited specialized health insurance benefits (such as Wee Care).

Employer sponsored self-funded health benefit plans are plans sponsored by an employer to provide health insurance benefits to the employer's employees. These plans may be funded entirely by the employer or by a combination of employer funds and amounts withheld from covered employees' wages. The risk of financial loss is borne by the employer. However, some self-funded plans purchase commercial stop loss coverage for added protection. These plans usually provide comprehensive major medical health insurance benefits, and may provide benefits only to the employee or to the employee and the employee's dependents.

Commercial insurance health benefit plans are plans marketed by an insurance company to provide health insurance benefits to insured persons. These plans are funded by the premiums collected from insured employers and individuals. The risk of financial loss is borne by the insurance company. Commercial insurance benefit plans can be issued as fee for service plans (such as Western Mutual Insurance Company), nonprofit health service plans (such as Regence

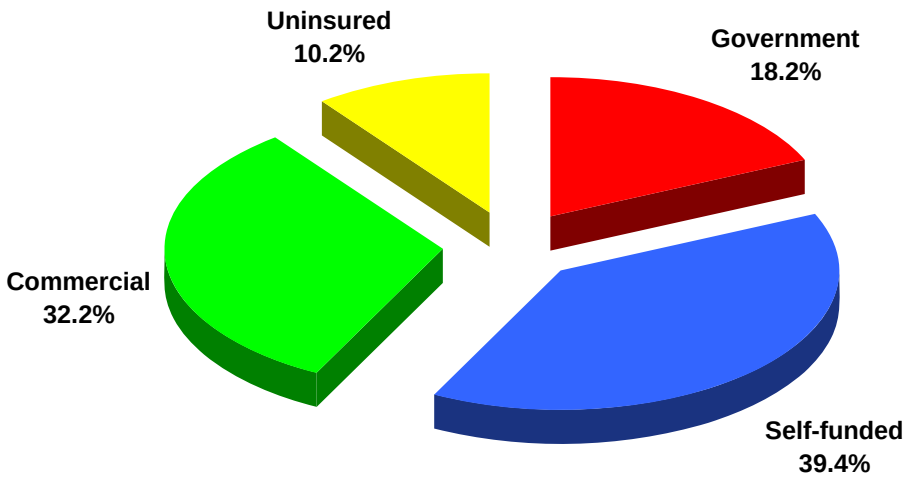
Blue Cross Blue Shield of Utah), health maintenance organizations (such as IHC Health Plans, Inc. dba SelectHealth, Inc.), and limited health plans (such as Delta Dental Care of Utah). The health insurance benefits provided will vary from comprehensive major medical health insurance to specified limited health insurance benefits such as dental, vision, or specified disease.

Each of these three sources of health insurance is regulated by a different set of laws and government programs. Government sponsored health benefit plans are regulated by Federal regulatory agencies like the Centers for Medicare and Medicaid Services (CMS). Employer sponsored self-funded health benefit plans are regulated for the most part under the Federal ERISA statute through the Department of Labor (DOL), the Centers for Medicare and Medicaid Services (CMS), and the Internal Revenue Service (IRS). Commercial health insurance is governed by state and federal law and is regulated by state insurance departments. This report focuses on the commercial health insurance market regulated by the Utah Insurance Department.

Estimate of Health Insurance Coverage in Utah

As mentioned previously, health insurance comes from three sources: government, employers, and commercial insurers. The Utah Insurance Department has attempted to estimate how much of the state is insured by each source of health insurance. The estimate is for comprehensive health insurance coverage only (also known as major medical). A general overview of the department's estimate is shown below in Figure 1 (see Table 1 for details).

Figure 1. Estimate of Health Insurance Coverage for 2004



Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2004 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution.

Caution should be used interpreting these results, however, as multiple data sources with differing methods were required to create this estimate. For example, membership data for government sponsored health benefit plans was obtained from the Utah Department of Health and the Centers for Medicare and Medicaid Services (CMS). Membership data for commercial health insurance was obtained from the Utah Accident & Health Survey, a survey conducted annually by the Utah Insurance Department.

The estimate for the uninsured was obtained from the Utah Health Status Survey. This survey is believed to be a more accurate estimate of the uninsured in Utah than the Census Bureau estimates developed from the Current Population Survey. The Current Population Survey tends to overestimate the number of uninsured in small states like Utah. The Utah Health Status Survey has a larger sample size and is a better measure of the uninsured for Utah.

Finally, membership for employer sponsored self-funded benefit plans was estimated using the best information available to the Insurance Department. Currently, there is no single source of self-funded membership data for Utah. As a result, a "best guess" estimate was created using a combination of membership data obtained from government sponsored plans, large self-funded employers, commercial health insurers who administer self-funded health benefit plans, and data from the Utah Health Status Survey. The result is imperfect, but it does provide an estimate of the self-funded population.

Given these limitations, the Utah Insurance Department estimates that eighteen percent of Utah residents were covered by government plans, thirty-nine percent were covered by self-funded plans, thirty-two percent were covered by commercial health insurance, and ten percent were uninsured (see Table 1).

Table 1. Estimate of Health Insurance Coverage for 2004

Coverage Type	Population Estimate	Percent of Population
Government Sponsored Plans	**448,559**	**18.2%**
Medicare	226,749	9.2%
Medicaid	171,302	6.9%
Children's Health Insurance Program (CHIP)	31,010	1.3%
Primary Care Network (PCN)	16,499	0.7%
Utah Comprehensive Health Insurance Pool (HIPUtah)	2,999	0.1%
Employer Sponsored Self-Funded Plans	**973,191**	**39.4%**
Plans Administered by Commercial Insurers	436,879	17.7%
Public Employee Health Program (PEHP)	179,087	7.3%
Federal Employee Health Benefit Plan (FEHBP)	83,867	3.4%
Other Known Self-Funded Plans	62,112	2.5%
Other Self-Funded Plans (Estimated)	211,246	8.6%
Commercial Health Insurance Plans	**796,080**	**32.2%**
Group	661,227	26.8%
Individual	134,853	5.5%
Uninsured	**251,400**	**10.2%**
Total	**2,469,230**	**100.00%**

Data Sources: Centers for Medicare & Medicaid Services, Deseret Mutual Benefit Administrators, Utah Comprehensive Health Insurance Pool, Public Employee Health Program, Utah Department of Health, Utah Insurance Department, and the Utah Population Estimates Committee.

Note: The estimate of the 2004 employer sponsored self-funded membership is based on limited data from commercial insurers and employers. It is not a complete count of the self-funded membership in Utah and should be used with caution.

Utah's Commercial Health Insurance Market

Commercial insurance carriers are companies in the business of managing risk. They accept the risk of loss to individuals or organizations in exchange for a premium. In doing so, the risk of loss is shared (or pooled) so that any one individual does not bear all the risk of loss.

Insurance companies report financial data to the Utah Insurance Department and the National Association of Insurance Commissioners (NAIC) on the health insurance business written in Utah. Health insurance premium data includes premiums from individual and group policyholders and from government sponsored programs such as Medicare and Medicaid. The premium reported does not include fees paid to insurers for administration of self-funded health benefit plans.

One measure of an insurer's financial health is the ratio of incurred losses to premiums earned. This ratio is called a loss ratio. A ratio of less than 100 indicates that an insurance company received more premium income than it paid out in claims. A ratio of more than 100 indicates that a company paid more in claims than it received in premium income. While the benchmarks vary depending on the type of insurance, health insurers generally try to maintain a loss ratio of less than 85 (85 cents of losses for every dollar of premium). If the loss ratio increases much beyond 85, an insurer may have more expenses than income and suffer a financial loss.

Commercial Health Insurance Market Overview

Among commercial insurers there is a broad universe of "health insurance" products. Commercial health insurance may include comprehensive health insurance, as well as insurance products that cover a specialized category such as long-term care, dental, vision, disability, accident, specified disease, or as a supplement to other kinds of health benefit plans.

There were 1,434 licensed insurers registered with the Insurance Department at the end of 2004. Of these, three hundred and sixty-five insurers reported health insurance business in Utah on their 2004 annual financial statements. These insurers represent all of the health insurance sold in Utah. Each insurer reported direct premium and losses in Utah, as well as total revenue and net income for their company.

Table 2 summarizes some of the characteristics of Utah's health insurance market that can be obtained from annual financial statements. Utah's health insurance market is highly concentrated among eight health insurers, who represent nearly 75 percent of the market. As a group, Utah's accident & health insurers had a loss ratio of 86 and net income of 5.68 percent (see Table 2). While looking at the loss ratio does give an accurate view of Utah's commercial health insurance market, net income (at this level) does not. In this case, net income is not a good measure of the financial health of Utah's market as less than one percent of total revenues reported were in Utah. A more accurate view is obtained by looking at state of domicile.

Domestic companies have a home office in Utah. Foreign insurers have a home office in another state. Nearly 78 percent of Utah's health insurance market is domestic. These 22 domestic insurers are much more representative of the Utah market as more than 65 percent of their total revenue comes from Utah business. Thus, their loss ratios and net income are a much more accurate measure of the Utah market. As a group, domestic insurers had a loss ratio of 90 and net income of 2.68 percent. Eight health insurers represent approximately 95 percent of Utah's domestic market. The remaining five percent of the market consists of life insurers and limited health plans.

There are 343 foreign insurers in Utah's commercial health insurance market, most of which are life insurers. These foreign insurers account for approximately 22 percent of Utah's market. Foreign insurers had a loss ratio of 70 for Utah business. Net income was 5.70 percent, but a negligible amount of total revenue (less than 0.01 percent) was from Utah business and is, therefore, not representative of Utah (see Table 2). Overall, foreign insurers have a small presence in Utah's health insurance market.

Table 2. Total Commercial Health Insurance Market by Insurer Type for 2004

		Utah Operations			National Operations	
Insurer Type	**Company Count**	**Direct Earned Premium**	**Market Share**	**Loss Ratio**	**Total Revenue**	**Net Income (% Rev)**
Domestic Insurers						
Health	8	$1,646,416,266	74.47%	89.83	$1,750,693,202	2.31%
Life	9	$67,265,672	3.04%	96.37	$852,909,109	3.41%
Limited Health Plan	5	$3,463,406	0.16%	60.08	$3,470,019	8.72%
Total Domestic	**22**	**$1,717,145,344**	**77.67%**	**90.03**	**$2,607,072,330**	**2.68%**
Foreign Insurers						
Fraternal	11	$562,796	0.03%	31.26	$7,726,341,373	5.10%
Life	288	$439,919,245	19.90%	72.74	$537,860,547,030	5.49%
Property & Casualty	44	$53,176,089	2.41%	50.09	$110,522,093,179	6.76%
Total Foreign	**343**	**$493,658,130**	**22.33%**	**70.25**	**$656,108,981,582**	**5.70%**
Utah Insurers						
Fraternal	11	$562,796	0.03%	31.26	$7,726,341,373	5.10%
Health	8	$1,646,416,266	74.47%	89.83	$1,750,693,202	2.31%
Life	297	$507,184,917	22.94%	75.88	$538,713,456,139	5.48%
Limited Health Plan	5	$3,463,406	0.16%	60.08	$3,470,019	8.72%
Property & Casualty	44	$53,176,089	2.41%	50.09	$110,522,093,179	6.76%
Total Utah	**365**	**$2,210,803,474**	**100.00%**	**85.61**	**$658,716,053,912**	**5.68%**

Data Sources: NAIC Financial Database and Utah Accident & Health Survey

Note: The total direct earned premium and total revenue reported here is based the annual financial statement data submitted by commercial insurers to the National Association of Insurance Commissioners (NAIC).

Commercial Health Insurance Market by Policy Type

Financial statement data is designed to measure the financial solvency of commercial insurers. As such, it is not designed to provide detailed information on a particular type of insurance. To compensate for this, Utah's commercial health insurers are required to participate in the Utah Accident & Health Survey. This survey collects data about the various types of health insurance in greater detail than the annual statement. Data was collected from 365 commercial health insurers who reported accident & health premium in Utah for 2004.

The top three policy types by market share were comprehensive health insurance (69 percent), the Federal Employee Health Benefit Plan (FEHBP) (9 percent), and Medicare Supplement (6 percent) (see Table 3).). The results of the survey differ slightly from the total accident & health reported on the 2004 annual statement. However, the difference is small. The net difference in total reported direct earned premium is less than 0.02 percent.

Table 3. Total Commercial Health Insurance Market by Policy Type for 2004

Policy Type	Company Count [a]	Member Count [b]	Direct Earned Premium	Market Share	Loss Ratio
Comprehensive	76	796,080	$1,515,423,760	68.56%	82.41
Medical Only	43	5,814	$2,489,166	0.11%	63.46
Medicare Supplement	78	82,080	$122,755,913	5.55%	79.94
Dental	72	321,143	$100,254,854	4.54%	70.95
Vision	23	97,699	$5,173,324	0.23%	73.25
FEHBP	4	56,878	$206,887,414	9.36%	95.22
Medicare [c]	2	1	$62,381	< 0.01%	221.92
Medicaid	2	-	$120,691	0.01%	NA
Stop Loss	45	188,444	$63,426,164	2.87%	71.35
Disability Income	180	381,815	$82,155,507	3.72%	98.15
Long Term Care	85	33,270	$27,237,679	1.23%	44.11
Credit A&H	51	149,738	$13,698,499	0.62%	37.39
Other	230	-	$70,779,853	3.20%	177.50
Total	**365**	**-**	$2,210,465,205	100.00%	85.44

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to total because an insurer may have more than one policy type.

[b] A total is not reported for the column "Member Count" and for "Other." A sum total of the membership counts of all types of health insurance would overestimate the actual number of persons covered by commercial health insurance due to uncontrolled double counting of members.

[c] Two companies reported claim activity for Medicare. This is probably due to discontinued policies in runoff and does not represent any active Medicare business in the state. Thus, the membership and premium reported here represent one company.

Consumer Complaints Against Commercial Health Insurance Companies

A key function of the Utah Insurance Department is to assist consumers with questions and concerns that they may have about commercial health insurance coverage. The primary agency within the Utah Insurance Department that assists consumers with health insurance issues is the Office of Consumer Health Assistance (OCHA).

The Office of Consumer Health Assistance seeks to provide a variety of needed services to health care consumers and policymakers, including (but not limited to):

- Assisting consumers in understanding their contractual rights and responsibilities, statutory protections and available remedies under their health program
- Providing health care consumer education (producing, collecting, disseminating educational materials; conducting outreach programs and other educational activities)
- Investigating and resolving complaints
- Assistance to those having difficulty accessing their health care plan because of language, disability, age, or ethnicity
- Providing information and referral to these persons as well as help with initiating a grievance process
- Analyzing and monitoring federal and state statutes, rules, and regulations that apply to health care consumers

On average, the Office of Consumer Health Assistance handles more than 10,000 consumer inquires each year (see Table 4). These inquiries range from simple questions about how to obtain health insurance coverage to complaints against a particular health insurance company.

Table 4. Estimated Number of Consumer Inquiries Handled by OCHA Staff: 1999 - 2004

Consumer Inquiries [a]	1999	2000	2001	2002	2003	2004
Telephone (in/out)	6,234	14,108	14,886	11,535	10,054	9,213
Walk-in	38	67	27	36	75	83
Other (in/out)	172	63	516	682	999	1,217
Total Inquires	**6,444**	**14,238**	**15,429**	**12,253**	**11,128**	**10,513**

Data Source: Utah Insurance Department

[a] The Office of Consumer Health Assistance (OCHA) was created July 1, 1999. Data reported here is only for consumer inquiries received after the creation of OCHA.

When a consumer inquiry involves a possible violation of the Utah Insurance Code by a commercial health insurance company, the Office of Health Assistance encourages consumers to file a written complaint. Once a written complaint is received, the Office of Consumer Health Assistance conducts an investigation and seeks to resolve the consumer complaint. The Office of Consumer Health Assistance tracks all written complaints made against commercial health insurers. These complaints are classified into three types: justified, question of fact, and unjustified (see Table 5).

Justified complaints. Justified complaints are those where the Insurance Department rules in favor of the consumer making the complaint. The Insurance Department determines that the complaint is warranted under the law and resolves the complaint by requiring the commercial health insurer to act to correct the problem.

Question of fact complaints. Question of Fact complaints are those where the complaint appears to be legitimate, but the Insurance Department was unable to make a ruling, either because there are unresolved questions about the facts of the case or because the department does not have the legal authority to do so. These complaints usually must be resolved by arbitration, mediation, or litigation.

Unjustified complaints. Unjustified complaints are those where the Insurance Department rules in favor of the commercial insurer as the insurer was judged to be acting within the bounds of the law. The department educates consumers as to their rights under the law and how health insurance contracts work.

As shown in Table 5, the total number of complaints declined steadily from 1999 to 2003, and then increased slightly during 2004. Generally, the number of justified and unjustified complaints remained fairly constant during this period. One exception to this pattern is 2001, where the number of justified complaints was much higher than the trend. The most significant change has been in the number of question of fact complaints, which have declined significantly since 1999. This trend towards fewer complaints is primarily due to an active effort by the Office of Consumer Health Assistance staff and Utah's health insurance industry to resolve consumer concerns before they rise to the level of a formal written complaint. This is a positive trend for the industry.

Table 5. Complaints Filed with OCHA by Type: 1999 - 2004

	Total		Justified		Question of Fact		Unjustified	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	70	21.5%	179	54.9%	77	23.6%
2000	244	100.0%	70	28.7%	123	50.4%	51	20.9%
2001	258	100.0%	127	49.2%	36	14.0%	95	36.8%
2002	174	100.0%	73	42.0%	27	15.5%	74	42.5%
2003	120	100.0%	54	45.0%	7	5.8%	59	49.2%
2004	135	100.0%	45	33.3%	20	14.8%	70	51.9%
Average	**210**	**100.0%**	**73**	**34.9%**	**65**	**31.1%**	**71**	**33.9%**

Data Source: Utah Insurance Department

In addition to tracking the number of written complaints and how they are resolved, the Utah Insurance Department also tracks the reason for the complaint. As shown in Table 6, on average, about two-thirds of all consumer complaints are due to claim handing issues, while policyholder services and marketing & sales issues account for the remainder (see Table 6).

Table 6. Complaints Filed with OCHA by Reason: 1999 – 2004

	Total [a]		Claim Handling		Policyholder Services		Marketing & Sales	
Year	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total	Count	Percent of Total
1999	326	100.0%	218	66.9%	80	24.5%	28	8.6%
2000	244	100.0%	163	66.8%	31	12.7%	50	20.5%
2001	265	100.0%	174	65.7%	74	27.9%	17	6.4%
2002	175	100.0%	125	71.4%	44	25.1%	6	3.4%
2003	120	100.0%	77	64.2%	39	32.5%	4	3.3%
2004	136	100.0%	65	47.8%	57	41.9%	14	10.3%
Average	**211**	**100.0%**	**137**	**64.9%**	**54**	**25.6%**	**20**	**9.5%**

Data Source: Utah Insurance Department

[a] A complaint may have more than one reason code, so totals may be slightly higher than the actual number of complaints.

Complaint ratios. Another measure of complaint activity is the complaint ratio. A complaint ratio is a measure of how many consumer complaints were received compared to the amount of business a commercial health insurer did in the state. Table 7 reports the average complaint ratios for the commercial health insurance market from 1999 to 2004 (see Table 7). Each complaint ratio reports the number of complaints per $1,000,000 in total direct earned premium. For example, a ratio of 1 means the insurer had 1 complaint for every $1,000,000 in premium.

Table 7. Complaint Ratios for the Commercial Health Insurance Market: 1999 – 2004

		Total		Justified		Question of Fact		Unjustified	
Year	Direct Earned Premium	Count	Ratio	Count	Ratio	Count	Ratio	Count	Ratio
1999	$1,887,679,133	326	0.17	70	0.04	179	0.09	77	0.04
2000	$2,053,470,759	244	0.12	70	0.03	123	0.06	51	0.02
2001	$2,171,040,169	258	0.12	127	0.06	36	0.02	95	0.04
2002	$2,181,743,936	174	0.08	73	0.03	27	0.01	74	0.03
2003	$2,180,896,901	120	0.06	54	0.02	7	< 0.01	59	0.03
2004	$2,210,803,474	135	0.06	45	0.02	20	0.01	70	0.03
Average	**$2,114,272,395**	**210**	**0.10**	**73**	**0.03**	**65**	0.03	**71**	0.03

Data Sources: NAIC Financial Database and Utah Insurance Department

As discussed previously, the Utah Insurance Department has seen a decline in the total number of complaints since 1999. This is primarily due to a decline in the number of question of fact complaints as part of a concerted effort by the Office of Consumer Health Assistance staff and the Utah health insurance industry to reduce the number of these kinds of complaints.

However, the number of justified and unjustified complaints has remained fairly constant, and this should be taken into account when looking at the pattern of the complaint ratios. As Table 7 shows, the average complaint ratio for the commercial market is about 0.10 for all complaints, and about 0.03 for each complaint type. Using this average as a benchmark, the complaint ratios for 2004 are generally lower than their six-year average.

Table 8 reports individual complaint ratios for commercial health insurance companies during 2004. The averages in Table 7 can be used to give perspective to these individual ratios. For example, a commercial health insurer with a justified complaint ratio of greater than 0.03 has a higher than average number of complaints, while a ratio of less than 0.03 means a lower than average number of complaints. It is also important to remember that a complaint ratio is only one aspect of evaluating a commercial health insurance company (see Table 8).

Table 8. Commercial Health Insurance Companies with Consumer Complaints during 2004

			Total [a]		Justified		Question Of Fact	
Company Name	**Direct Earned Premium**	**Market Share**	**Count**	**Ratio**	**Count**	**Ratio**	**Count**	**Ratio**
Altius Health Plans Inc	$245,899,666	11.1%	7	0.03	4	0.02	-	-
American Family Life Asr Co Columbus	$18,015,608	0.8%	3	0.17	2	0.11	-	-
American Heritage Life Ins Co	$2,394,824	0.1%	1	0.42	1	0.42	-	-
American Medical Security Life InsCo	$5,323,497	0.2%	1	0.19	-	-	-	-
Bankers Life & Cas Co	$5,014,725	0.2%	2	0.40	2	0.40	-	-
Cigna Healthcare Of UT Inc	$12,208,275	0.6%	1	0.08	-	-	1	0.08
Conseco Health Ins Co	$4,334,286	0.2%	3	0.69	-	-	1	0.23
Conseco Senior Health Ins Co	$1,483,871	0.1%	1	0.67	-	-	-	-
Continental Assur Co	$1,273,827	0.1%	1	0.79	-	-	-	-
Educators Mut Ins Assoc	$32,862,640	1.5%	1	0.03	-	-	-	-
Fortis Ins Co	$2,205,300	0.1%	6	2.72	3	1.36	-	-
Great West Life & Annuity Ins Co	$4,101,188	0.2%	1	0.24	1	0.24	-	-
Guardian Life Ins Co Of Amer	$1,812,383	0.1%	1	0.55	-	-	-	-
Hartford Life & Accident Ins Co	$15,936,469	0.7%	1	0.06	-	-	-	-
IHC Health Plans Inc	$641,329,607	29.0%	17	0.03	5	0.01	-	-
Mega Life & Health Ins Co The	$7,545,741	0.3%	5	0.66	-	-	1	0.13
Metropolitan Life Ins Co	$22,253,187	1.0%	3	0.13	-	-	-	-
Mid West Natl Life Ins Co Of TN	$3,346,280	0.2%	2	0.60	-	-	1	0.30
Mutual Of Omaha Ins Co	$9,368,611	0.4%	3	0.32	1	0.11	-	-
Pacific Life & Annuity Co	$2,282,279	0.1%	1	0.44	1	0.44	-	-
Provident Life & Accident Ins Co	$2,382,082	0.1%	1	0.42	1	0.42	-	-
Prudential Ins Co Of Amer	$4,491,139	0.2%	4	0.89	1	0.22	2	0.45
Pyramid Life Ins Co	$1,534,401	0.1%	5	3.26	-	-	3	1.96
Regence BCBS of UT	$632,622,513	28.6%	18	0.03	5	0.01	5	0.01
Standard Life & Accident Ins Co	$3,060,446	0.1%	1	0.33	-	-	-	-
Teachers Ins & Ann Assoc Of Amer	$2,393,026	0.1%	1	0.42	-	-	-	-
Transamerica Life Ins Co	$1,386,743	0.1%	2	1.44	-	-	-	-
United American Ins Co	$7,122,034	0.3%	8	1.12	3	0.42	3	0.42
United Healthcare Ins Co	$113,816,801	5.1%	10	0.09	3	0.03	1	0.01
United States Life Ins Co In NYC	$2,609,082	0.1%	1	0.38	-	-	-	-
United Teacher Assoc Ins Co	$1,185,679	0.1%	3	2.53	2	1.69	-	-
Unum Life Ins Co Of Amer	$10,300,858	0.5%	4	0.39	1	0.10	1	0.10
Top 32 companies with complaints [b]	**$1,821,897,068**	82.4%	**119**	**0.07**	**36**	**0.02**	**19**	**0.01**
Remaining 14 companies with complaints [c]	$6,260,317	0.3%	16	2.56	9	1.44	1	0.16
Companies without complaints	$382,646,089	17.3%	-	-	-	-	-	-
Total Commercial Market	**$2,210,803,474**	**100.00%**	**135**	**0.06**	**45**	**0.02**	**20**	**0.01**

Data Sources: NAIC Financial Database, Utah Accident & Health Survey, and Utah Insurance Department.

[a] Total complaints includes Justified, Question of Fact, and Unjustified. Unjustified are not shown separately.
[b] Describes all companies with at least $1,000,000 in total direct earned premium.
[c] Separate complaint ratios were not calculated for companies with less than $1,000,000 in total direct earned premium because it produces distorted ratios that cannot be directly compared to other companies.

Utah's Comprehensive Health Insurance Market

Comprehensive health insurance makes up nearly 69 percent of the commercial health insurance market in the state of Utah (see Table 3) and affects approximately 32 percent of Utah residents (see Table 1). It is the only type of major medical health benefit plan directly regulated by the Utah Insurance Department. The following analysis of the comprehensive market examines various aspects of the market including state of domicile, group size, health benefit plan type, and market trends.

Comprehensive Market by Domicile

State of domicile refers to the state in which an insurer's home office is located. An insurer can only be domiciled in one state. Domestic insurers generally have a larger presence in their state of domicile than foreign insurers. Their local status may assist them in negotiating more favorable provider contracts and creating larger provider networks than foreign insurers.

Approximately 91 percent of the comprehensive health insurance market is served by domestic insurers and is highly concentrated among 11 insurers. Sixty-five foreign insurers represent the remaining market share. Domestic insurers reported a slightly higher premium per member per month ($163) than foreign insurers ($150). Loss ratios were lower for foreign insurers (see Table 9).

Table 9. Total Comprehensive Market by Domicile for 2004

Domicile	Company Count	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [a]
Domestic	11	724,121	$1,385,273,308	91.41%	83.85	$163
Foreign	65	71,959	$130,150,452	8.59%	67.05	$150
Total	**76**	**796,080**	**$1,515,423,760**	**100.00%**	**82.41**	**$162**

Data Source: Utah Accident & Health Survey

[a] Direct earned premium per member per month

Comprehensive Market by Group Size

Comprehensive health insurance plans are sold either as an individual, a group, or a conversion policy. Individual policies are sold directly to individual consumers. In contrast, group policies are sold as a single contract to a group of individuals, such as a group of employees. Groups with 2 to 50 employees are classified as small employer group. Groups with 51 or more employees are classified as large employer group. Conversion policies are sold to individuals whose eligibility for a group policy ended and who "converted" their group policy membership to an individual policy. Conversion policies are typically classified as individual policies.

Group policies reported higher premium per member per month ($171) than individual policies ($119). This is probably due to differences in underwriting practices. In individually underwritten policies, insurers have more ability to set rates based on health criteria. As a result, sicker individuals who would incur higher medical costs would be given policy offers with higher premiums than healthier individuals. However, less expensive policies are more likely to be issued than expensive ones. So the individual market's lower premium may reflect the tendency for healthier individuals to get and accept more affordable health insurance coverage.

In the case of small employer groups, policies are underwritten based on the health status of the group rather than the individual, with each group containing both healthy and sick individuals. However, because the group is small (between 2 to 50 members) the health status of an individual person can have a significant impact on rating. Rates are based on the initial health status of the group, but can change at the annual renewal if the health status of the group declines. Small groups can experience rate increases of up to 15 percent at renewal due to changes in health status. Additional increases are also imposed due to changes in the group's demographics and increasing costs of health care.

In contrast, large group policies are typically underwritten without taking individual health status into account. Each group is a mix of healthy and sick individuals, and the larger the group, the less impact the health status of an individual person can have on costs. However, because less underwriting is used, sicker individuals may freely enter the group, which can increase the overall cost of the group. Thus, medical claims costs tend be higher and policyholders are charged higher premiums to pay for these additional costs. However, large group premiums tend to be less expensive for sick individuals compared to what they would pay if they were underwritten in the individual or small group markets.

Conversion policies had the highest premium per member per month ($259). This is due to the fact that conversion policies are often issued to individuals who are ill, who have more expensive medical needs, and who have a critical need to continue coverage even though their group policy is no longer available. Less than one percent of the market was insured by conversion policies (see Table 10).

Table 10. Total Comprehensive Market by Group Size for 2004

Group Size	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Total Individual	52	134,853	$191,226,285	12.62%	79.42	$119
Individual	45	132,765	$184,812,541	12.20%	77.53	$117
Conversion	17	2,088	$6,413,744	0.42%	133.73	$259
Total Group	43	661,227	$1,324,197,475	87.38%	82.84	$171
Small Group (2-50)	21	233,098	$435,401,464	28.73%	80.34	$159
Large Group (50+)	31	428,129	$888,796,011	58.65%	84.06	$177
Total Comprehensive	**76**	**796,080**	**$1,515,423,760**	**100.00%**	**82.41**	**$162**

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to total because an insurer may have more than one plan type.
[b] Direct earned premium per member per month

Comprehensive Market by Plan Types

During 2005, the Utah Insurance Department conducted a review of the product categories used in the Utah Accident & Health Survey. As part of this review, feedback was received from many of Utah's health insurers. Based on the information obtained from the product category review, the product categories were revised as explained below (see "Methods Overview" for details).

In this report, comprehensive health insurance plans are classified into four major plan types: Fee for Service (FFS), Preferred Provider Organization (PPO), Health Maintenance Organization (HMO), and Health Maintenance Organization with Point of Service features (HMO with POS). These plan types differ in the amount of managed care used to maintain quality and manage the cost of health care services. The term "managed care" refers to the methods many third-party payers use to ensure quality care (such as disease management programs) and to reduce utilization and cost of health care services (such as pharmacy benefit managers and medical review boards). HMO plans generally have the most management of care; whereas FFS plans generally have the least. All of these plans provide comprehensive health services consistent with the basic benefit plan required by the Utah Insurance Code.

A Fee for Service plan (FFS) refers to a traditional indemnity plan. Under a FFS plan, members can use any health care provider they choose (as long as the services are a covered benefit on the insurance contract). There are no preferred provider networks and all services are reimbursed at the same cost sharing level (usually a fixed percentage of billed charges).

A Preferred Provider Organization plan (PPO) refers to a health plan that offers a network of "preferred" providers that have contracted to provide health care services for a reduced fee. Members have financial incentives to use this network of preferred providers, as costs for health care services are typically lower. Members are also free to also use providers outside of the network, but services are reimbursed at a lower rate and members must pay a larger portion of the cost for health care services. PPO plans usually include deductibles, co-pays, or coinsurance. This category includes PPO plans where members must obtain preauthorization prior to using non-preferred providers.

A Health Maintenance Organization plan (HMO) refers to a "prepaid" health insurance plan where policyholders pay a fixed monthly fee for comprehensive major medical coverage. An HMO plan usually covers more preventative care services than other kinds of plans, but also manages care more than other kinds of plans. Services are provided through a network of health care providers that have negotiated a fee schedule with the HMO. Members enrolled in the plan generally pay a fixed co-pay for physician visits and drugs. Services are usually not available outside the provider network, except for emergencies.

A Health Maintenance Organization with Point of Service features plan (HMO with POS) is a type of licensed HMO. A HMO with POS refers to an HMO plan that gives members the option to use providers who are outside of the HMO network for certain types of medical services (not emergencies), but at a lower reimbursement rate where members bear a larger

portion of the cost for health care services. Except for this out of network option, a HMO with POS functions like a standard HMO.

HMO, HMO with POS, and PPO plans are considered managed care plans. FFS plans typically do not involve any form of managed care. Nearly 90 percent of Utah's comprehensive health insurance market involves some type of managed care; with more than 66 percent of the comprehensive health market in an HMO or HMO with POS plan (see Table 11).

Premium per member per month was significantly higher for FFS plans compared to the other plan types, while HMO plans were the lowest. This is consistent with the attempts many managed care plans make to control costs (see Table 11).

Table 11. Total Comprehensive Market by Plan Type for 2004

Plan Type	Company Count [a]	Member Count	Direct Earned Premium	Market Share	Loss Ratio	Premium PMPM [b]
Fee for Service	54	90,840	$175,391,056	11.57%	80.11	$187
Preferred Provider Organization	40	165,030	$326,920,155	21.57%	76.97	$164
Health Maintenance Organization	6	403,965	$737,613,375	48.67%	83.98	$154
HMO with Point of Service features [c]	3	136,244	$275,498,540	18.18%	86.12	$170
Other	1	1	$634	< 0.01%	NA	$53
Total	**76**	**796,080**	**$1,515,423,760**	**100.00%**	**82.41**	**$162**

Data Source: Utah Accident & Health Survey

[a] Company count column does not add up to total because an insurer may have more than one plan type.
[b] Direct earned premium per member per month
[c] IHC Health Plans, Inc., an HMO, (now DBA SelectHealth, Inc.) provides Point of Service benefits in conjunction with its affiliated indemnity company IHC Benefit Assurance Company, Inc. (now DBA SelectHealth Benefit Assurance, Inc.)

High deductible health plans. The federal government has recently authorized a new type of insurance product called a High Deductible Health Plan (HDHP). High deductible health plans are comprehensive health insurance plans with deductibles and limits that are much higher than traditional insurance options. Health insurers have offered insurance products with higher deductibles in the past, however, one of the key features that make these plans different is that the deductible levels of these plans are set by federal statute and plans that comply with federal guidelines are eligible for use with a saving vehicle called a Health Savings Account (HSA). Payments made into a HSA are tax deductible and can be used to pay for current health care expenses or saved the future. When the health care expenses reach the level of the deductible, the high deductible health plan pays for covered health care expenses beyond the deductible. High deductible health plans can also be used in conjunction with Health Reimbursement Arrangements (HRA). HRAs are similar to HSAs, except the employer owns the savings account (rather than the employee) and only the employer can deposit funds into the account.

As of 2004, only two health insurers reported HDHP business and fewer than 2,000 members had such plans. This is likely due to that fact that the insurers who did choose to offer these plans, did so late in the calendar year, limiting the marketing of such plans. For now, these plans will be aggregated with the rest of the market data, as little useful information can be gained yet from a separate analysis. In the future, as more data becomes available, a separate analysis may be presented.

Comprehensive Market Trends

This section reports on four significant trends in Utah's comprehensive health insurance market: the number of insurers, the cost of insurance, the number of insured members, and the financial status of the market. Each measure represents a different aspect of the market's "health."

Trends in the number of insurers. The Utah Insurance Department continues to monitor the number of commercial health insurance companies that are providing comprehensive health insurance. The department has data regarding the number of comprehensive health insurers from 1999 to 2004.

Based on this data, the Insurance Department has found evidence of a decline in the number of commercial health insurance companies. In 1999 there were 123 commercial health insurance companies who reported comprehensive health insurance business during the year. As of 2004, only 76 companies were reporting comprehensive health insurance business during the year. Although the numbers may appear significant, this decline is not affecting the competitiveness of the health insurance market.

Under current market conditions, the typical health insurer needs to be large enough to be able to drive membership volume to providers in order to remain competitive. While there is no absolute rule for how large an insurer needs to be, an insurer with a large number of members has more leverage in contract negotiations with providers. This arrangement can benefit both consumers and providers. Consumers may benefit from lower prices and providers may benefit from a higher volume of clients. Many small health insurers cannot "drive volume" as effectively as a large insurer.

Most of the decline in the number of comprehensive health insurers has occurred primarily among smaller health insurers, particularly foreign (non-domiciled) insurers with less than 1 million dollars in comprehensive health insurance premium (see Table 12). In many cases, these small foreign health insurers are providing coverage for "non-situated" policies, that is, commercial health insurance policies that are not filed in the state of residence of the employee. These are often policies issued in another state to an employer with less than 25 percent of their employees living in the state of Utah. The premium is reported as covering a Utah resident, but the policy itself was not sold in Utah or filed with the Utah Insurance Department. Many of these companies are not actively selling health insurance in the Utah health insurance market and are only here because an employee of the company they sold health insurance to is currently a resident in the state. As a result, many of these insurers leave the market when the employees leave the company or the company leaves Utah. Thus, many of these smaller foreign health insurers are covering a special class of Utah residents and may not be really competing directly in the mainstream Utah health insurance market. The decline, therefore, may be due to factors that are more external to the market and is probably not affecting the market very much (see also Table 20 for a list of the relative market shares of Utah's comprehensive health insurers).

Table 12. Changes in the Number of Comprehensive Insurers: 1999 - 2004

Comprehensive Insurer Category	1999	2000	2001	2002	2003	2004	Net Change
Domestic Insurers							
Greater than 100 Million	4	4	4	4	3	3	-1
Between 100 Million and 10 Million	5	4	5	3	4	4	-1
Between 10 Million and 1 Million	6	6	4	3	2	3	-3
Less than 1 Million	3	3	1	2	1	1	-2
Total Domestic	**18**	**17**	**14**	**12**	**10**	**11**	**-7**
Foreign Insurers							
Greater than 100 Million	0	0	0	0	0	0	0
Between 100 Million and 10 Million	1	2	2	1	1	1	0
Between 10 Million and 1 Million	16	15	12	12	11	11	-5
Less than 1 Million	88	83	75	64	54	53	-35
Total Foreign	**105**	**100**	**89**	**77**	**66**	**65**	**-40**
All Insurers							
Greater than 100 Million	4	4	4	4	3	3	-1
Between 100 Million and 10 Million	6	6	7	4	5	5	-1
Between 10 Million and 1 Million	22	21	16	15	13	14	-8
Less than 1 Million	91	86	76	66	55	54	-37
Total Utah	**123**	**117**	**103**	**89**	**76**	**76**	**-47**

Data Source: Utah Accident & Health Survey

Note: Health insurers are counted by relative size, broken into four categories measured in millions of US dollars.

In contrast, there has been little change in the number of large domestic health insurers that represent the core of the comprehensive health insurance market (see Table 12). These large health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market.

***Trends in the cost of insurance*.** Utah's comprehensive health insurance premium premiums are increasing at a significant rate. For example, from 1999 to 2004, the average premium per member per month for comprehensive health insurance has increased on average about 9.9 percent per year. In 2004, the average premium per member per month for comprehensive health insurance was 8.7 percent higher than in 2003. Utah's rate of increase, in comparison with national employer data, appears to be following a national trend (see Table 13). This suggests that Utah's health insurance market is experiencing similar cost pressures as other parts of the country.

Table 13. Comprehensive Premium Compared to National Economic Trends: 1999 – 2004

	Comprehensive Premium in Utah				National Economic Trends (Annual Percent Change)		
Year	Total Premium [a]	Premium PMPM [b]	Premium PMPY [c]	Annual Percent Change	Health Insurance Premium [d]	Overall Inflation	Workers' Earnings
1999	$1,161,373,601	$101	$1,212	N/A	5.3%	2.3%	3.6%
2000	$1,239,046,717	$111	$1,332	9.9%	8.2%	3.1%	3.9%
2001	$1,308,837,635	$123	$1,476	10.8%	10.9%	3.3%	4.0%
2002	$1,328,724,448	$133	$1,596	8.1%	12.9%	1.6%	2.6%
2003	$1,405,078,420	$149	$1,788	12.0%	13.9%	2.2%	3.0%
2004	$1,515,423,760	$162	$1,944	8.7%	11.2%	2.3%	2.2%

Data Sources: Utah premium data are from the Utah Accident & Health Survey from 1999 to 2004. The national trend data used as a comparison comes from the Kaiser/HRET Employer Health Benefits Survey report for 2004.

[a] Total direct earned premium
[b] Direct earned premium per member per month
[c] Direct earned premium per member per year
[d] "Health Insurance Premium" trends are based on premium changes for a family of four in an employer based plan.

One of the main causes of the trend towards higher premiums is a steady increase in the underlying cost of health care. Utah's health care costs, like the United States as a whole, have increased at a significant rate. For example, from 1999 to 2004, the average loss per member per month for comprehensive health insurance has increased about 8 percent per year. In 2004, the average loss per member per month for comprehensive health insurance was 7.2 percent higher than in 2003 (see Table 14). Nationally, these costs are being driven by a number of factors, particularly increases in pharmacy and hospital costs (Strunk, Ginsburg, & Gabel, 2002; Strunk and Ginsburg, 2003; Strunk and Ginsburg, 2004; Strunk, Ginsburg, & Cookson, 2005). Government mandates, increased consumer demand, and litigation, also appear to be important factors (PriceWaterhouseCoopers, 2002).

The rising cost of health care creates significant economic pressure on comprehensive insurers. For example, if Utah's comprehensive insurers had kept premiums at 1999 levels and costs had continued to increase, by 2004, the industry's loss ratio would be approximately 133. In other words, the industry would be paying out nearly $1.33 in claims for every $1.00 in premium. No business can afford to lose money at such rates for long, so comprehensive insurers responded by raising premium to levels that would cover their costs.

In addition to claim costs, comprehensive insurers also have to pay general administrative costs such as general business expenses and the cost of processing claims. Furthermore, commercial health insurers are also required by state law to maintain adequate financial reserves and to remain financially solvent. This is because health insurers are selling "a promise to pay in the future." When a consumer purchases a health insurance contract, they are buying a promise to pay for future health care costs under certain conditions. Insurers cannot pay claims on behalf of consumers without adequate funds to do so.

Table 14. Comprehensive Losses Compared to National Health Care Spending: 1999 - 2004

	Comprehensive Losses in Utah				National Health Care Spending (Annual Percent Change)				
Year	Loss Ratio [a]	Losses PMPM [b]	Losses PMPY [c]	Annual Percent Change	All	Inpatient Hospital	Outpatient Hospital	Physician	Prescription Drugs
1999	89.49	$91	$1,092	N/A	9.9%	2.6%	11.6%	6.7%	18.1%
2000	84.59	$94	$1,128	3.3%	9.3%	4.0%	9.8%	7.7%	14.2%
2001	85.06	$104	$1,248	10.6%	11.3%	8.6%	14.5%	7.8%	13.5%
2002	82.91	$110	$1,320	5.8%	10.7%	8.2%	13.0%	7.9%	13.1%
2003	84.06	$125	$1,500	13.6%	8.4%	6.1%	11.1%	6.4%	8.9%
2004	86.12	$134	$1,608	7.2%	8.2%	6.2%	11.3%	6.4%	7.2%

Data Sources: Utah loss data are from the Utah Accident & Health Survey from 1999 to 2004. The national health care spending data are from the Milliman USA Health Cost Index ($0 deductible) as reported by Strunk, Ginsburg, and Cookson (2005).

[a] Ratio of direct incurred losses to direct earned premium
[b] Direct incurred losses per member per month
[c] Direct incurred losses per member per year

For Utah employers and consumers, this trend means that health care is getting more expensive. For a single individual, the average premium per member per year increased from $1,212 in 1999 to $1,944 in 2004. This is an increase of approximately 60 percent over the last six years. Both consumers and employers are being impacted by this increase. In most cases, employers pay a significant portion of this premium. Nationally, employers pay more than two-thirds of the premium cost (Kaiser/HRET, 2005). However, many employers are responding to the rising cost of health care by increasing the employee's portion of the premium, reducing benefits, or looking at new plan designs such as defined benefit plans. These changes may be difficult for some consumers to accept because the rate of increase in consumer income has not kept pace with the rate of increase in premiums (see Table 15).

Table 15. Changes in Comprehensive Premium and Per Capita Income: 1999 - 2004

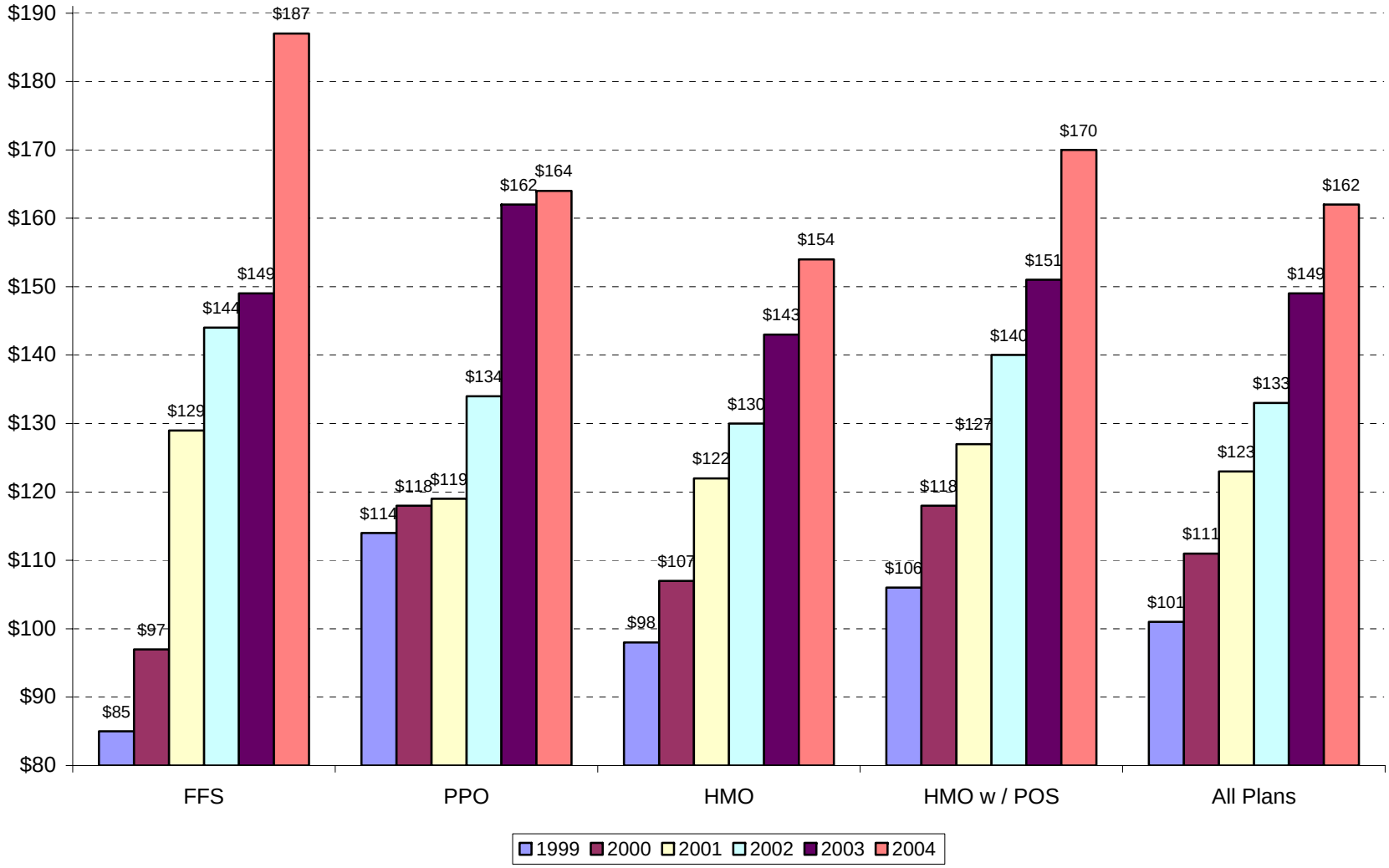
	1999	2000	2001	2002	2003	2004
Premium PMPY [a]	$1,212	$1,332	$1,476	$1,596	$1,788	$1,944
Annual percent change in Premium	-	9.9%	10.8%	8.1%	12.0%	8.7%
Per Capita Income in Utah	$22,393	$23,878	$24,711	$24,898	$25,230(p)	$25,870(f)
Annual percent change in Income	-	6.6%	3.5%	0.8%	1.3%	2.5%

Data Sources: Utah premium data are from the Utah Accident & Health Survey. Per capita income data are from the Economic Report to the Governor (2005).

[a] Direct earned premium per member per year
p "Projected"
f "Forcasted"

The recent premium increases have affected all of the different comprehensive health insurance plan types. Over the last six years, managed care products such as HMO plans increased less than plans with fewer cost controls. The largest increase has been among FFS plans. However, given their large market share in Utah, HMO and HMO with POS plans have had the most impact on premiums trends in the market (see Figure 2).

Figure 2. Comprehensive Premium PMPM by Plan Type: 1999 - 2004



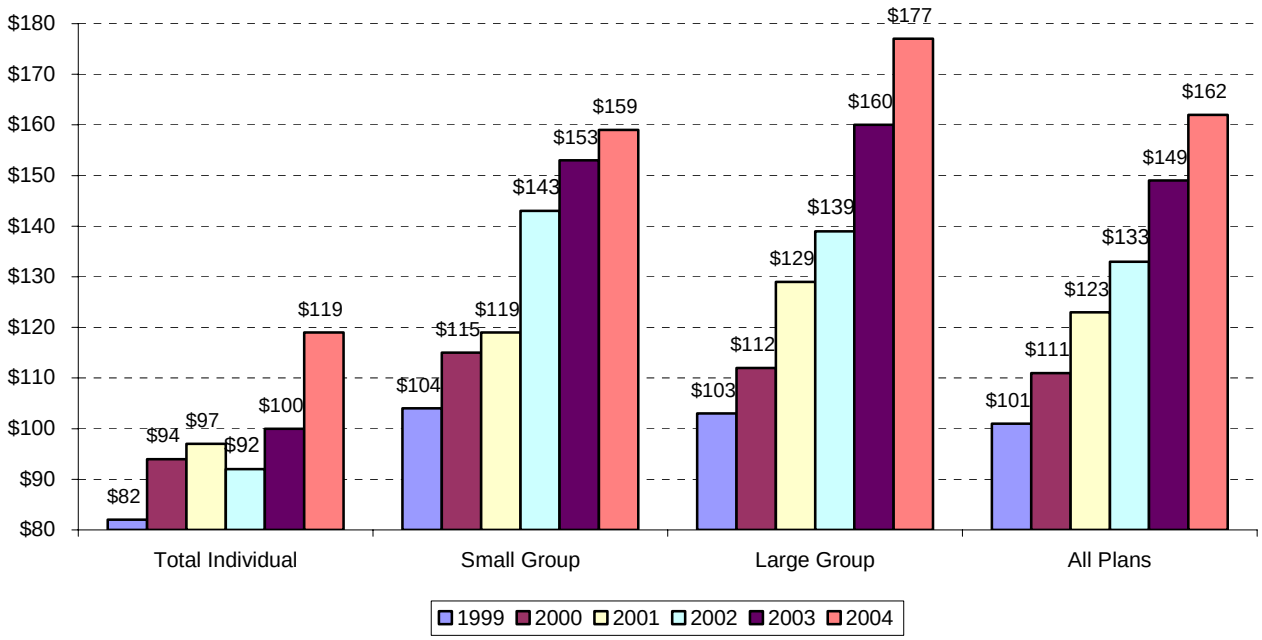
Data Source: Utah Accident & Health Survey

Note: Results may differ slightly from previous reports due to changes in product type categories.

Premium increases have been fairly uniform among different group sizes. Significant premium increases occurred in both large and small group plans. Individual plans, in comparison, have experienced relatively lower increases over time; however, this pattern changed during 2004 with individual plans reporting a much larger increase than in the past (see Figure 3). As mentioned previously, the cost differences between individual and group products are probably due to differences in underwriting practices (see "Comprehensive Market by Group Size" for further discussion).

Increases in large group plan premiums have had the most impact on the premium trends in the market over the last six years. This is primarily because, at least in the comprehensive health insurance market, more Utah residents are covered by large group plans than by any other type. As a result, changes in this category have a larger impact on market averages than changes in the individual or small group markets.

Figure 3. Comprehensive Premium PMPM by Group Size: 1999 - 2004



Data Source: Utah Accident & Health Survey

Although Utah has continued to experience significant increases in the cost of comprehensive health insurance coverage, when one compares Utah premiums on a per member per month basis to national data from the National Association of Insurance Commissioners (NAIC), Utah's premium appears to be lower than the national average (see Table 16). For example, during 2004, the average premium for Utah's comprehensive health insurers was approximately $162 per member per month. In contrast, the average premium for commercial health insurers reporting comprehensive health insurance to the Nation Association of Insurance Commissioners (NAIC) financial database was $219 per member per month. Although this comparison does not control for differences in benefits, health status, or demographics, this data suggests that Utah's average premium is lower than the average premium reported to the NAIC.

Table 16. Comparison of Utah Premium to National Premium: 1999 - 2004

	Utah Estimate		National Estimate [b]	
Year	Premium PMPM for Comprehensive Health Insurance [a]	Annual Percent Change	Premium PMPM for Comprehensive Health Insurance [b]	Annual Percent Change
1999	$101	-	$129	-
2000	$111	9.9%	$143	10.9%
2001	$123	10.8%	$149	4.2%
2002	$133	8.1%	$177	18.8%
2003	$149	12.0%	$199	12.4%
2004	$162	8.7%	$219	10.1%

Data Sources: Utah Accident & Health Survey and the NAIC Financial Database

[a] Premium per member per month is the average premium per person per month for comprehensive health insurance. This is the estimated cost of health insurance for all types of hospital and medical coverage on a per person basis. A division into single and family rates is not possible using data from the Utah Accident & Health Survey or the NAIC Financial Database.

[b] Only data for Health Maintenance Organizations was available for 1999 and 2000.

Note: The Utah estimate is based on data obtained from the Utah Accident & Health Survey for comprehensive health insurance. The national estimate is based on data obtained from the NAIC Financial Database. The data represents the average premium per member per month for comprehensive health insurance business as reported by commercial health insurers who filed on the 2004 financial statement for health related insurance business. Both data sources include only information on commercial health insurers.

However, the premium that consumers actually pay may differ significantly from the market average depending on their individual circumstances. Furthermore, although Utah's premiums may be lower by this measure, Utah's premiums are increasing at rates that are very similar to comprehensive insurers nationally (9.9 percent for Utah, 11.2 percent for comprehensive insurers reporting to the NAIC).

Trends in the number of members. Since 1999, the number of residents insured by comprehensive health insurance as a relative percentage of Utah's total population has declined by about 12 percent. During this same time period Utah's population has increased by more than 15 percent.

As shown in Table 17, from 1999 to 2004, the individual and small group markets have steadily increased (basically maintaining their relative distribution in Utah's population), while the conversion and large group markets have declined. The largest change occurred in the large group market, which declined by nearly 13 percent. Most of these changes occurred between 1999 and 2002. During 2003, the decline in membership stopped and increased slightly from 2002, however, another significant decline in membership occurred in 2004 (see Table 17).

Table 17. Changes in Comprehensive Membership by Group Size: 1999 – 2004

Group Size	1999	2000	2001	2002	2003	2004	*Net Change* [a]
Individual	96,455	99,034	110,295	126,662	129,522	132,765	*+36,310*
As percent of population [b]	**4.51%**	**4.41%**	**4.80%**	**5.42%**	**5.43%**	**5.38%**	***+0.87%***
Conversion	3,272	2,949	2,139	2,059	2,029	2,088	*-1,184*
As percent of population	**0.15%**	**0.13%**	**0.09%**	**0.09%**	**0.09%**	**0.08%**	***-0.07%***
Total Individual	99,727	101,983	112,434	128,721	131,551	134,853	*+35,126*
As percent of population	**4.66%**	**4.54%**	**4.90%**	**5.50%**	**5.51%**	**5.46%**	***+0.80%***
Small Group	200,377	208,561	208,100	237,050	224,872	233,098	*+32,721*
As percent of population	**9.37%**	**9.28%**	**9.06%**	**10.14%**	**9.43%**	**9.44%**	***+0.07%***
Large Group	655,112	624,524	534,484	447,623	465,842	428,129	*-226,983*
As percent of population	**30.63%**	**27.80%**	**23.28%**	**19.14%**	**19.53%**	**17.34%**	***-13.29%***
Total Group	855,489	833,085	742,584	684,673	690,714	661,227	*-194,262*
As percent of population	**39.99%**	**37.08%**	**32.34%**	**29.28%**	**28.96%**	**26.78%**	***-13.22%***
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	796,080	*-159,136*
As percent of population	**44.66%**	**41.62%**	**37.24%**	**34.78%**	**34.47%**	**32.24%**	***-12.42%***
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	2,469,230	*+330,216*
As percent of population	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	***0.00%***

Data Sources: Utah Accident & Health Survey and Utah Population Estimates Committee

[a] "Net Change" measures the difference in the absolute number of members from 1999 to 2004 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 15 percent over this period.

[b] "As percent of population" measures the relative percentage of Utah's total population in each particular year.

The reasons for this general decline in membership are complex. Various market forces are in operation. To begin with, the decline in the number of comprehensive health insurers could have contributed to the decline (see Table 12), but this is unlikely. It more likely that the recent increases in the cost of health care and insurance premiums may have led some policyholders to seek less expensive kinds of coverage and this may show up as restructuring in the market place (i.e., shifting membership). Some of this restructuring is evident among the different plan types in the market (see Table 18) and can be observed somewhat in the available data.

First, there has been a steady increase in the number of residents with individual plans. This is largely due to an increase in individual HMO policies in two large managed care insurers. Premiums for individual policies have remained low compared to other options in the market. This may be a significant incentive to switch from more costly types of coverage. However, these lower rates are really only available to those with good health, because individual policies have stricter underwriting requirements than group plans.

Table 18. Changes in Comprehensive Membership by Plan Type: 1999 – 2004

Plan Type	1999	2000	2001	2002	2003	2004	*Net Change* [a]
Fee for Service	84,600	89,756	58,075	55,465	93,385	90,840	*+6,240*
As percent of population [b]	**3.96%**	**4.00%**	**2.53%**	**2.37%**	**3.91%**	**3.68%**	***-0.28%***
Preferred Provider Organization	149,026	158,804	185,184	208,362	167,239	165,030	*+16,004*
As percent of population	**6.97%**	**7.07%**	**8.07%**	**8.91%**	**7.01%**	**6.68%**	***-0.28%***
Health Maintenance Organization	517,583	481,995	431,560	404,460	416,952	403,965	*-113,618*
As percent of population	**24.20%**	**21.45%**	**18.80%**	**17.29%**	**17.48%**	**16.36%**	***-7.84%***
HMO with Point of Service	182,798	183,574	177,408	141,198	143,994	136,244	*-46,554*
As percent of population	**8.55%**	**8.17%**	**7.73%**	**6.04%**	**6.04%**	**5.52%**	***-3.03%***
Other	21,209	20,939	2,791	3,909	695	1	*-21,208*
As percent of population	**0.99%**	**0.93%**	**0.12%**	**0.17%**	**0.03%**	**< 0.01%**	***-0.99%***
Total Comprehensive	955,216	935,068	855,018	813,394	822,265	796,080	*-159,136*
As percent of population	**44.66%**	**41.62%**	**37.24%**	**34.78%**	**34.47%**	**32.24%**	***-12.42%***
Utah Population	2,139,014	2,246,544	2,295,971	2,338,761	2,385,358	2,469,230	*+330,216*
As percent of population	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**	***0.00%***

Data Sources: Utah Accident & Survey and Utah Population Estimates Committee

[a] "Net Change" measures the difference in the absolute number of members from 1999 to 2004 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 15 percent over this period.

[b] "As percent of population" measures the relative percentage of Utah's total population in each particular year.

Note: Results may differ slightly from previous reports due to changes in product type categories.

Second, there has been a decline in the number of residents with individual conversion policies. This is primarily due to changes in the number of conversion policies in two large managed care insurers. Conversion policies tend to have a limited duration because they are the result of a person in a group policy who "converts" their group plan into an individual conversion policy. They are intended to act as a temporary bridge between employer group coverage and some other kind of coverage. As a result, one would not expect the number of conversion policies to become very large in the market.

Third, there has also been a steady increase in the number of residents covered by policies in the small group market. This suggests that small employers are maintaining insurance coverage despite the rising premiums in Utah's comprehensive market, which is positive sign for the Utah's small group market.

Fourth, the largest change in the market over this period has been a significant decrease in the number of residents within large group policies. This is largely explained by declines in HMO membership (see Table 18) within four managed care insurers and changes to a large group student plan. Large group plans are typically sold to large employers. Large employers are the most likely to provide health insurance benefits to their employees and the most likely to provide these benefits through a self-funded health benefit plan. So a decline in this sector could be due to a shift from commercial health insurance to self-funded health benefit plans, rather than an increase in the uninsured or in government sponsored-health benefit plans. This is difficult to confirm with the available data, but when the five insurers most effected were asked, some were able to confirm that a shift from commercial to self-funded had occurred, while others did not provide a specific reason for the change other than their clients had non-renewed their contracts and that this was simply restructuring in the market.

Additional support for a shift by large employers from the commercial health insurance market to self-funded health benefit plans can be found in the available data on the uninsured and government sponsored health benefit plans. A review of the available data suggests that there has been a relatively small increase in the uninsured and government sponsored health benefit plans during this period.

For example, recent surveys of the uninsured by the U.S. Census Bureau (Mills, 2002; Mills, 2003; DeNavas-Walt, Proctor, & Mills, 2004), the Utah Department of Health (Office of Public Health Assessment, 2004; Office of Public Health Assessment, 2002; Office of Public Health Assessment, 2001), and Utah's commercial health insurance industry (Utah Health Insurance Association/Utah Association of Health Underwriters, 2001) suggest that Utah's uninsured rate has remained fairly constant between 1999 and 2003. Most of the surveys report an uninsured rate of about 9 percent. Federal surveys report a higher rate (between 13 and 14 percent), but report minimal changes in the uninsured during this period. Thus, changes in uninsured are unlikely to be a significant factor in the decline in membership from 1999 to 2003.

However, the most recent data from the Utah Health Status Survey suggests that Utah's uninsured rate increased from 9.1 percent in 2003 to 10.2 percent as of 2004 (Office of Public Health Assessment, 2006). While the available data cannot confirm this, the 1.1 percent increase

in the uninsured during 2004 could be a contributing factor in the more recent declines in comprehensive membership.

The available data on Utah's government sponsored health benefit plans shows a moderate increase in membership (see Table 19), but this increase can only account for a small portion of the decline in the commercial market and could be connected to other factors such as changes in the economy and population increases. Most of the increases are in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Table 19. Changes in Government Sponsored Health Benefit Plans: 1999 - 2004

Plan Type	1999	2000	2001	2002	2003	2004	*Net Change* [a]
Medicare	201,217	206,056	210,169	214,507	220,221	226,749	*+25,532*
Medicaid	132,397	132,569	139,426	154,784	156,031	171,302	*+38,905*
Children's Health Insurance Program (CHIP)	10,500	17,391	24,448	24,505	23,761	31,010	*+20,510*
Utah Health Assistance Program (UMAP)	3,623	3,615	3,346	4,447	-	-	*-3,623*
Primary Care Network (PCN)	-	-	-	-	17,228	16,499	*+16,499*
Utah Comprehensive Health Insurance Pool (HIPUtah)	994	1,265	1,767	2,347	2,854	2,999	*+2,005*
Government Sponsored Health Benefit Plans	348,731	360,896	379,156	400,590	420,095	448,559	*+99,828*
As percent of population [b]	**16.30%**	**16.06%**	**16.51%**	**17.13%**	**17.61%**	**18.17%**	***+1.87%***

Data Sources: Centers for Medicare & Medicaid Services and Utah Department of Health

[a] "Net Change" measures the difference in the absolute number of members from 1999 to 2004 as well as the change in membership as a relative percentage of Utah's total population. Please note that Utah's population increased by approximately 15 percent over this period.

[b] "As percent of population" measures the relative percentage of Utah's total population in each particular year.

In summary, changes in the individual and small group market do not seem to account for the significant declines in the large group market. The available data are consistent with a shift by large employers from the commercial health insurance market to self-funded health benefit plans. This would be a reasonable response from large employers seeking to control the rate of health care costs. Self-funding can be attractive to large employers due to fewer state mandates and greater control over costs due to an increased freedom in health benefit plan design. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

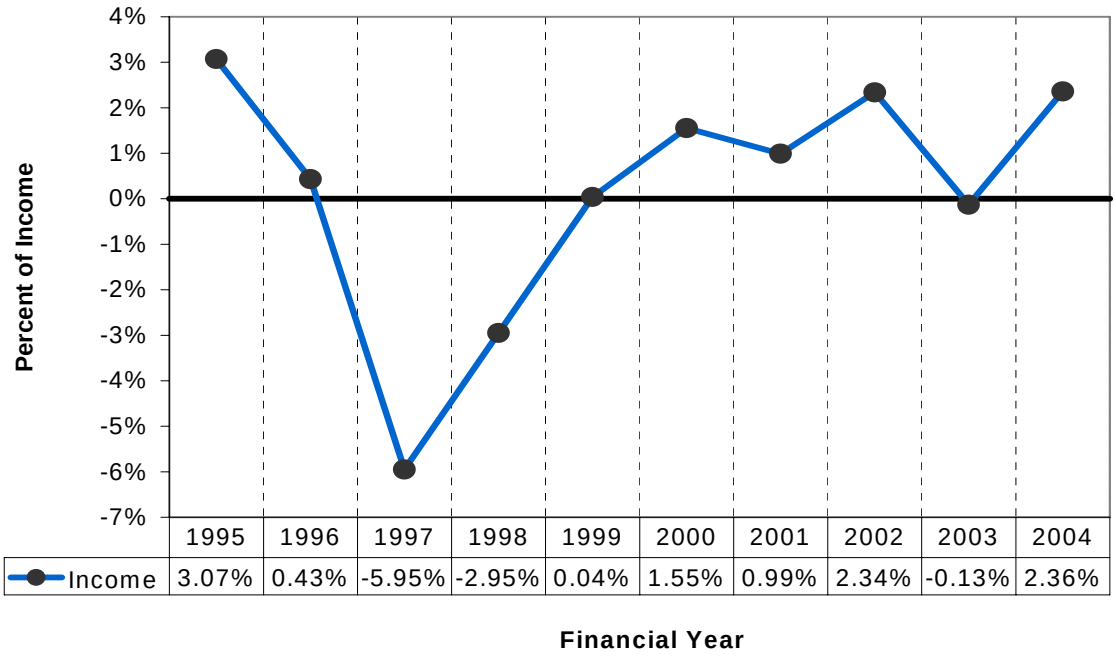
Financial trends. To measure the current financial condition of the market, the financial results of the top seven managed care health insurers in Utah were used as an index of Utah's comprehensive health insurance market. These companies were selected because: 1) they represent 90 percent of the 2004 comprehensive health insurance market, 2) they receive more than 75 percent of their revenues from comprehensive health insurance, 3) nearly all of their

revenues come from Utah business, and 4) their primary business model is that of a health insurer. Thus, these companies are Utah's best examples of pure comprehensive health insurers and they can provide an index of how well comprehensive health insurers are doing in the Utah market over time.

Health insurers, whether for-profit or non-profit, need enough income after expenses to fund state-mandated reserve requirements, to reinvest in new equipment and new markets, and to acquire and maintain needed capital. The results of this index indicate that Utah's comprehensive health insurance market has experienced an average gain of 0.22 percent in net income per year since 1995 (see Figure 4). However, this trend has improved since 1998, with an average of 1.25 percent in net income per year over the last six years, although the market reported a slight loss of 0.13 percent for 2003. During 2004, the financials of these companies improved with an average net income of 2.36 percent. Although health insurance premiums continue to rise, Utah's health insurers are maintaining conservative financial margins and appear to be charging premiums that allow them to cover their costs.

Although health insurers are reporting narrow financial margins, all of Utah's core health insurers are financially solvent and have adequate reserves to cover health insurance claims. Utah's health insurers are financially stable and are able to meet their financial obligations to consumers.

Figure 4. Income After Expenses For Managed Care Health Insurers: 1995 - 2004



Data Source: NAIC Financial Database

Note: This figure represents the ratio of net income to total revenue as reported on the NAIC annual statement for the seven largest managed care health insurers that have been operating in Utah since 1995.

Summary

Health insurance is an important issue for the people of Utah. Utah's residents receive their health insurance coverage through health plans sponsored by the government, employers, and commercial health insurers. The commercial health insurance market is the only source of health insurance directly regulated by the Utah Insurance Department.

Approximately 69 percent of Utah's commercial health insurance market is comprehensive health insurance (also known as major medical). The comprehensive health insurance industry serves approximately 32 percent of Utah residents. The typical policy in this industry is an employer group policy with a managed care plan administered by a domestic health insurer.

A key function of the Utah Insurance Department is to assist consumers with questions and concerns they may have about insurance coverage. The Office of Consumer Health Assistance (OCHA) is the primary agency within the Utah Insurance Department that handles consumer concerns about their health insurance. Based on the number of complaints received by OCHA, most Utah consumers are receiving good consumer service from Utah's commercial health insurers. For example, the number of consumer complaints received by the Utah Insurance Department has declined every year since 1999. This is primarily due to efforts by OCHA's staff and the Utah health insurance industry to resolve consumer concerns before they rise to the level of a formal complaint. This is a positive trend for Utah consumers and the Utah health insurance industry.

Over the last six years, there have been four significant trends in the comprehensive health insurance market that the Utah Insurance Department continues to monitor: changes in the number of insurers, the cost of comprehensive health insurance, the number of Utah residents with comprehensive health insurance, and the financial status of the health insurance market.

The number of comprehensive health insurers has declined steadily since 1999. This change is mainly due to a decrease in the number of small foreign health insurers participating in the comprehensive health insurance market. In contrast, there has been little or no change in the number of medium to large health insurers. Large domestic health insurers account for more than 90 percent of the market and provide a solid pool of health insurers. These insurers are financially solvent and provide an important level of strength, stability, and choice for Utah's comprehensive health insurance market. This decline has affected a small portion of the marketplace and the number of large health insurers offering comprehensive health insurance has remained stable since 1999.

Like the rest of the United States, Utah's comprehensive health insurance market is experiencing significant increases in the costs of health insurance. For example, the average premium per member per month increased from $149 during 2003 to $162 during 2004, an increase of 8.7 percent. This growth in premiums is being driven primarily by increases in the underlying cost of health care that health insurers contract to pay for. For example, Utah's health insurers experienced a 7.2 percent increase in losses per member per month from 2003 to 2004. These pricing pressures are not unique to Utah and are being driven by national health care

trends that are affecting most states in a similar way. Although these increases are difficult, Utah's health insurance premiums appear to be lower than the national average. Based on data from the NAIC financial database, the average cost for comprehensive health insurance coverage was $219 per member per month during 2004. Although this comparison does not control for differences in benefits, health status, or demographics, this national estimate is higher than the average in Utah's commercial market. However, the premium that consumers actually pay will differ from the market average depending on their individual circumstances.

The percentage of Utah residents covered by comprehensive health insurance has declined steadily from 1999 to 2004. Based on the available information, this trend appears to be primarily due to a shift by large employers and other large group plans from commercial insurance to self-funding arrangements. However, recent increases in the uninsured and the number of residents covered by government sponsored health benefit plans may also be contributing factors.

Over the last ten years the top insurers in the comprehensive health insurance industry have experienced an average financial gain of 0.22 percent. This trend has improved since 1999, however, with the core of the industry experiencing an average financial gain of 1.25 percent over the last six years. Although premiums have increased significantly during this period, the financial data from Utah's health insurers suggest that they are operating on very conservative financial margins and appear to be only charging enough premiums to cover their costs. Generally, Utah's health insurers are financially stable and are able to meet their financial obligations to Utah consumers.

As requested by the Utah Legislature, the Utah Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are reported in the Appendix.

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Appendix

Recommendations

As requested by the Utah Legislature, the Utah Insurance Department has developed a list of recommendations for legislative action that have the potential to improve Utah's health insurance market. These recommendations are listed by order of importance:

1) HIPUtah funding by law to be actuarially sound.

2) Encourage the development of, and the requirement to use, electronic data interchange standards to foster a Level IV System of Electronic Medical Records.

3) Create a preferred drug list (PDL) for use by publicly funded health care programs.

4) Create a prescription purchasing plan because prescription costs continue to climb resulting in cost shifting to individuals and increased cost to payers.

5) Reform the current medical malpractice system with a no-fault dispute resolution system modeled after workers' compensation insurance.

6) Require transparency of sales in the health insurance industry.

7) Remove state mandates from groups 2-50, but allow a small employer the option to have any state mandate at an appropriate cost.

8) Create a fully funded Joint Executive/Legislative Task Force to study the rising costs of health care.

List of Comprehensive Health Insurers

Table 20. List of Comprehensive Insurers during 2004

Company Name	State of Domicile	Direct Earned Premium	Market Share	Loss Ratio
IHC Health Plans Inc (DBA SelectHealth Inc)	UT	$641,208,916	42.31%	86.60
Regence BCBS of UT	UT	$361,234,261	23.84%	81.66
Altius Health Plans Inc	UT	$245,819,495	16.22%	83.71
United Healthcare Ins Co	CT	$88,907,977	5.87%	71.07
Healthwise	UT	$50,392,333	3.33%	73.76
United Healthcare Of UT Inc	UT	$46,976,633	3.10%	77.76
Cigna Healthcare Of UT Inc	UT	$12,201,758	0.81%	71.14
IHC Benefit Assur Inc (DBA SelectHealth Benefit Assur Co Inc)	UT	$11,952,087	0.79%	82.61
Aetna Life Ins Co	CT	$7,900,468	0.52%	49.66
Mega Life & Health Ins Co The	OK	$6,485,763	0.43%	45.51
Deseret Mut Ins Co	UT	$6,397,673	0.42%	92.54
American Medical Security Life InsCo	WI	$4,892,121	0.32%	50.87
Educators Health Care	UT	$4,560,693	0.30%	73.63
Western Mut Ins	UT	$4,210,414	0.28%	82.30
State Farm Mut Auto Ins Co	IL	$3,482,838	0.23%	72.14
Mid West Natl Life Ins Co Of TN	TN	$3,297,497	0.22%	45.61
Pacific Life & Annuity Co	AZ	$2,202,601	0.15%	58.85
Fortis Ins Co	WI	$2,140,660	0.14%	46.67
Connecticut General Life Ins Co	CT	$1,618,206	0.11%	63.67
Continental Assur Co	IL	$1,259,025	0.08%	36.27
New York Life Ins Co	NY	$1,096,386	0.07%	92.53
Unicare Life & Health Ins Co	DE	$1,079,276	0.07%	58.17
American Natl Life Ins Co Of TX	TX	$854,176	0.06%	42.93
Guarantee Trust Life Ins Co	IL	$801,717	0.05%	114.23
Benchmark Ins Co	KS	$448,013	0.03%	57.93
National Health Ins Co	TX	$392,894	0.03%	73.65
Chesapeake Life Ins Co	OK	$359,124	0.02%	8.76
Educators Mut Ins Assoc	UT	$319,045	0.02%	158.97
Trustmark Life Ins Co	IL	$301,403	0.02%	69.50
New England Life Ins Co	MA	$283,904	0.02%	26.93
American Heritage Life Ins Co	FL	$266,868	0.02%	32.50
Golden Rule Ins Co	IL	$252,484	0.02%	186.35
American Underwriters Life Ins Co	AZ	$229,794	0.02%	78.76
John Alden Life Ins Co	WI	$189,097	0.01%	6.15
Best Life And Health Ins Co	TX	$155,784	0.01%	54.11
World Ins Co	NE	$145,239	0.01%	135.66
Great West Life & Annuity Ins Co	CO	$144,005	0.01%	84.55
Metropolitan Life Ins Co	NY	$131,625	0.01%	33.31
Trustmark Ins Co	IL	$119,152	0.01%	90.21
United Of Omaha Life Ins Co	NE	$77,355	0.01%	82.12
Prudential Ins Co Of Amer	NJ	$74,907	< 0.01%	123.43
Mutual Of Omaha Ins Co	NE	$74,249	< 0.01%	307.21
Fortis Benefits Ins Co	IA	$72,035	< 0.01%	23.63
Conseco Ins Co	IL	$46,342	< 0.01%	27.06
American Republic Ins Co	IA	$45,815	< 0.01%	36.18
Union Labor Life Ins Co	MD	$38,470	< 0.01%	9.25
Pyramid Life Ins Co	KS	$37,170	< 0.01%	40.03
Principal Life Ins Co	IA	$34,628	< 0.01%	37.12
AXA Equitable Life Ins Co	NY	$34,352	< 0.01%	990.53
Symetra Life Ins Co	WA	$30,177	< 0.01%	301.83
Continental General Ins Co	NE	$29,711	< 0.01%	13.28
Fidelity Security Life Ins Co	MO	$18,644	< 0.01%	176.29

Life Investors Ins Co Of Amer	IA	$15,565	< 0.01%	32.92
Great West Life Assur Co	MI	$14,972	< 0.01%	111.35
Republic American Life Ins Co	TX	$11,600	< 0.01%	258.29
Columbia Universal Life Ins Co	TX	$11,162	< 0.01%	251.92
Guardian Life Ins Co Of Amer	NY	$8,882	< 0.01%	852.09
Celtic Ins Co	IL	$7,587	< 0.01%	1,766.82
American Natl Ins Co	TX	$6,255	< 0.01%	11.93
New Era Life Ins Co	TX	$4,794	< 0.01%	0.00
United Heritage Life Ins Co	ID	$2,959	< 0.01%	58.50
Humana Ins Co	WI	$2,771	< 0.01%	808.37
Allianz Life Ins Co Of North Amer	MN	$2,497	< 0.01%	609.45
Reserve Natl Ins Co	OK	$1,614	< 0.01%	0.00
Physicians Mut Ins Co	NE	$1,504	< 0.01%	25.80
Pacificare Life & Health Ins Co	IN	$1,353	< 0.01%	67.55
Thrivent Financial For Lutherans	WI	$1,112	< 0.01%	-34.62
American States Ins Co	IN	$649	< 0.01%	NA
Security Financial Life Ins Co	NE	$634	< 0.01%	0.00
Jefferson Pilot Lifeamerica Ins Co	NJ	$632	< 0.01%	0.00
Mony Life Ins Co	NY	$524	< 0.01%	0.00
United Teacher Assoc Ins Co	TX	$490	< 0.01%	-1.84
Protective Life Ins Co	TN	$300	< 0.01%	0.00
Central United Life Ins Co	TX	$295	< 0.01%	0.00
Illinois Mut Life Ins Co	IL	$189	< 0.01%	0.00
Centre Life Ins Co	MA	$160	< 0.01%	0.00
All Comprehensive Insurers	**76**	**$1,515,423,760**	**100.00%**	**82.41**

Data Source: Utah Accident & Health Survey

List of Health Insurance Mandates in Utah

Coverage mandates

Required by Federal statute:

1. Preexisting conditions (31A-22-605; NAIC Standard)
2. Dependent coverage from the moment of birth or adoption (31A-22-610)
3. Coverage through a noncustodial parent (31A-22-610.5; Social Security Act)
4. Open enrollment for child coverage ordered by a court (31A-22-610.5; Social Security Act)
5. Medicare supplemental insurance, including preexisting conditions provision (31A-22-620; NAIC Standard; Title XVIII of the Social Security Amendment, 1965)
6. Individual and small group guaranteed renewability (31A-30-107; Health Insurance Portability and Accountability Act, 1997)
7. Individual and small group limit on exclusions and preexisting conditions (31A-30-107; Preexisting conditions are required by Federal Statute)
8. Small group portability and individual guaranteed issue (31A-30-108; Health Insurance Portability and Accountability Act, 1997)
9. Maternity coverage on groups of 15 or more employees (Pregnancy Discrimination Act, Public Law 95-555, 1978)
10. COBRA benefits for employees of employer with 20 or more employees (Consolidated Omnibus Budget Reconciliation Act, Public Law 99-272, 1985)

Required by State statute:

1. Policy provision standards (31A-22-605)
2. Dependent coverage to age 26 (31A-22-610.5)
3. Extension of policy for a dependent child with a disability (31A-22-611)
4. Conversion privileges for an insured former spouse (31A-22-612)
5. Mini-COBRA benefits for employees of employer with less than 20 employees (31A-22-722; State expansion of Federal COBRA requirements).

Benefit mandates

Required by Federal statute:

1. Maternity stay minimum limits (31A-22-610.2; Newborn & Mothers Health Protection Act, Public Law 105-35, 1997)
2. Pediatric vaccines – level of benefit (31A-22-610.5, Omnibus Budget Reconciliation Act, 1993)
3. Preauthorization of emergency medical services (31A-22-627; Federal Patient Bill of Rights Plus Act)
4. OB/GYN as primary care physician (31A-22-624)

5. Mastectomy provisions (31A-22-630; Women's Health & Cancer Rights Act, 1996)

Required by State statute:

1. $4,000 minimum adoption indemnity benefit (31A-22-610.1)
2. Dietary products for inborn metabolic errors (31A-22-623)
3. Catastrophic coverage of mental health conditions (31A-22-625; Required by Federal statute, but State statute is more protective than Federal requirements)
4. Diabetes coverage (31A-22-626)
5. Standing referral to a specialist (31A-22-628)
6. Basic Health Care Plan in individual market (31A-22-613.5 and 31A-30-109)

Provider mandates

Required by Federal statute:

None

Required by State statute:

1. Preferred provider contract provisions, including 75 percent reimbursement provision for non-preferred providers, quality assurance program, nondiscrimination, and grievance process (31A-22-617)
2. HMO payments to noncontracting providers in rural areas (31A-8-501)

Statutory Requirements and Methods Overview

Statutory Requirements

Utah Code Annotated (U.C.A.) § 31A-2-201(7) requires that the Utah Insurance Department produce an annual evaluation of the health insurance market. The statutory requirements for this evaluation are shown below:

(7) (a) Each year, the commissioner shall:
(i) conduct an evaluation of the state's health insurance market;
(ii) report the findings of the evaluation to the Health and Human Services Interim Committee before October 1; and
(iii) publish the findings of the evaluation of the department website.
(b) The evaluation shall:
(i) analyze the effectiveness of the insurance regulations and statutes in promoting a healthy, competitive health insurance market that meets the needs of Utahns by assessing such things as the availability and marketing of individual and group products, rate charges, coverage and demographic changes, benefit trends, market share changes, and accessibility;
(ii) assess complaint ratios and trends within the health insurance market, which assessment shall integrate complaint data from the Office of Consumer Health Assistance within the department;
(iii) contain recommendations for action to improve the overall effectiveness of the health insurance market, administrative rules, and statutes; and
(iv) include claims loss ratio data for each insurance company doing business in the state.
(c) When preparing the evaluation required by this section, the commissioner may seek the input of insurers, employers, insured persons, providers, and others with an interest in the health insurance market.

Methods Overview

This report primarily uses data from two sources: the NAIC Financial Database and the Utah Accident & Health Survey. It also uses information from national data sources and government agencies. The report will continue to evolve as required to meet the needs of the Utah Legislature.

Qualifications. The accuracy of the information in this publication depends on the quality of the data supplied by commercial health insurers. While the information presented here is believed to be correct and every effort has been made to obtain accurate information, the Utah Insurance Department cannot control for variations in the quality of the data supplied by commercial health insurers or differences in how insurers interpret NAIC and Utah Insurance Department data submission guidelines.

NAIC Financial Database. The NAIC Financial Database is a nationwide database maintained by the National Association of Insurance Commissioners. It contains data obtained from insurance companies' annual financial statements. Data was obtained for companies writing

commercial health insurance in Utah during 1999, 2000, 2001, 2002, 2003, and 2004. The data summarizes the total accident & health premium and losses in Utah reported by commercial health insurers to the NAIC. It does not provide information on a particular type of health insurance.

Utah Accident & Health Survey. The Utah Accident & Health Survey is submitted annually to the Utah Insurance Department. All commercial health insurers are required to file this report. This survey provides detailed information on commercial insurance activity in Utah. It includes information that allows the Insurance Department to estimate trends in Utah's commercial health insurance market, including market share, number of covered lives, loss ratios, and cost of insurance. Data is available for 1999, 2000, 2001, 2002, 2003, and 2004. The data includes information on approximately 400 companies each year.

The survey is divided into five parts: accident & health insurance, long term care & Medicare supplement insurance, comprehensive health insurance, administration of self-funded plans, and marketing of accident & health insurance. The accident & health insurance portion of the survey must balance to the total accident & health insurance business reported on the Utah business section of the annual statement. The comprehensive insurance section includes detailed information on plan types, group size, and year-end member months. This additional detail allows the Insurance Department to evaluate changes in the comprehensive health insurance market with much greater accuracy.

During 2005, the Utah Insurance Department conducted a review of the product categories being used in the Utah Accident & Health Survey. As part of this review, feedback was received from many of Utah's health insurers. Based on the information obtained from the product category review, the product categories were revised as follows.

Fee for Service plans (FFS), Preferred Provider Organization plans (PPO), and Health Maintenance Organization plans (HMO) remained unchanged. The previously used Point of Service plan category was split into two categories: Health Maintenance Organization with Point of Service features (HMO with POS) and Preferred Provider Plan with Point of Service features (PPO with POS).

In order to make the previously collected data comparable with the new categories, licensed HMOs who had reported POS plans were recoded to HMO with POS plans, while licensed accident & health insurers who had reported POS plans were recoded as PPO with POS and merged with PPO plans. This reclassification was made in order to minimize confusion regarding point of service products and, hopefully, increase understanding of the various insurance product options available in Utah's commercial health insurance market.

In the case of HMO with POS plans, offering an option to use out of network providers for some types of non-emergency services is a distinctive feature for a HMO plan. Furthermore, HMO with POS plans play a significant role in Utah's comprehensive health insurance market and cover a large number of Utah residents. Given these issues, this plan type was analyzed separately from other HMO plans.

In contrast, PPO with POS plans have few functional differences from a standard PPO and the Utah Insurance Code does not distinguish between PPO plans with or without point of service features (such as preauthorization requirements) as both offer a preferred provider network with an out of network option. Also, PPO with POS plans have a limited role in Utah's market place and few residents have this type of coverage. Given the limited differences of PPO with POS plans from a standard PPO plan and their minor status in the market place, this plan was analyzed together with the other PPO plans.

The Utah Accident & Health Survey does not specifically measure differences in benefit structure, demographics, or the health status of the commercially insured population. Despite this limitation, this survey (along with the NAIC Financial Database) is a valuable source of data on Utah's commercial health insurance market and as such provides useful information on commercial health insurance.